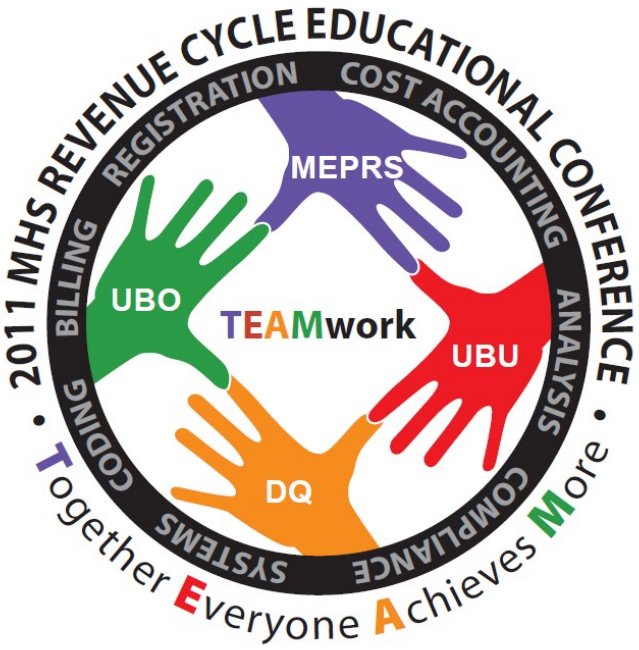


March 15, 2011

- "…the dilemmas we face today in providing for – and paying for – our national defense."

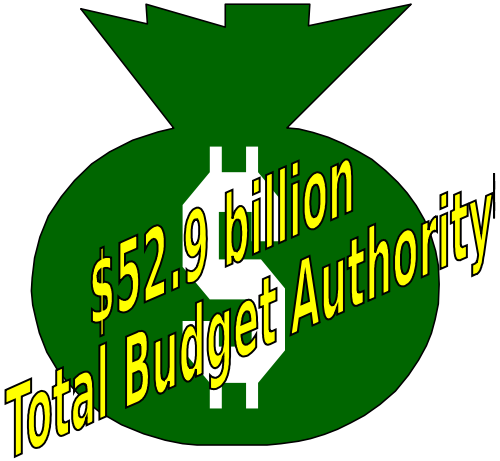
- "Leaving aside the sacred obligation we have to America's wounded warriors, health care costs are eating the Defense Department alive, rising from $19 billion a decade ago to roughly $50 billion – roughly the entire foreign affairs and assistance budget of the State Department."

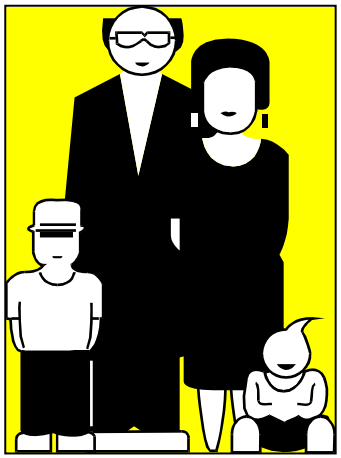
Agenda

- 2012 Review
- Front End Assessment

2012 Review

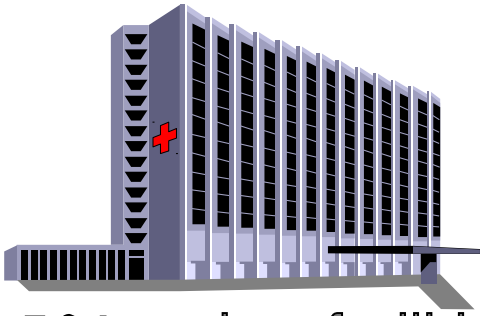
Fiscal Year 2012 Request Snapshot



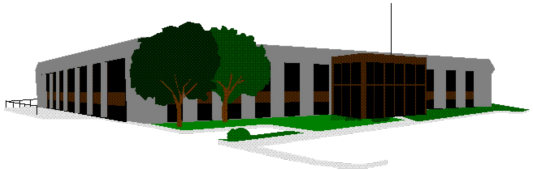


9.6 million
Beneficiaries

144 thousand military
and civilian medical personnel



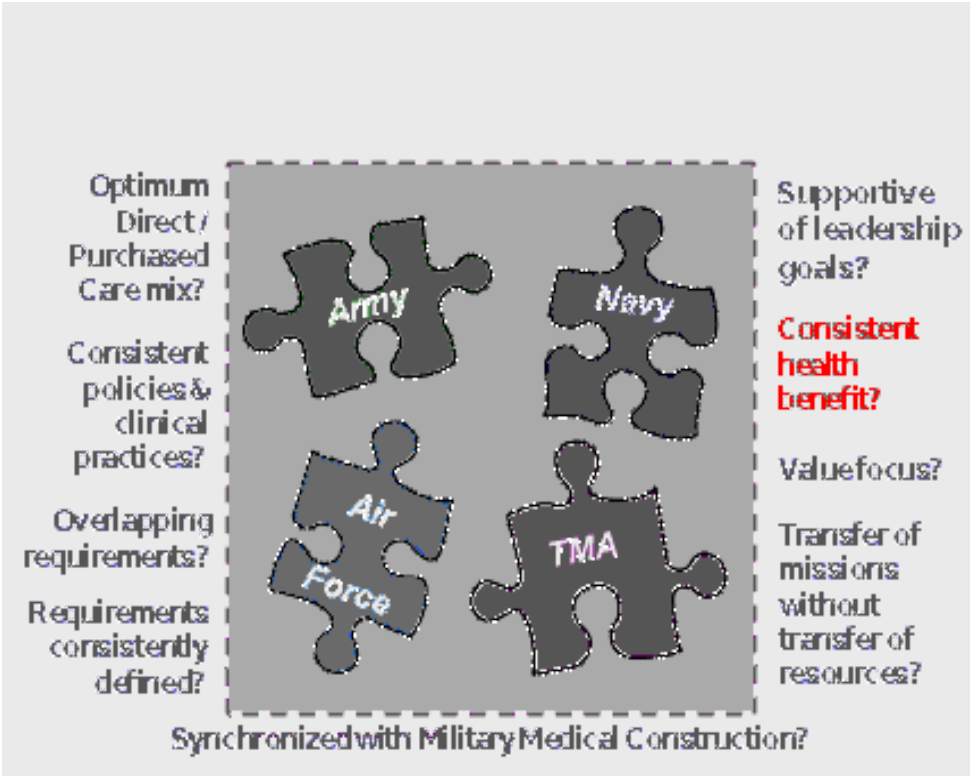
56 Inpatient facilities

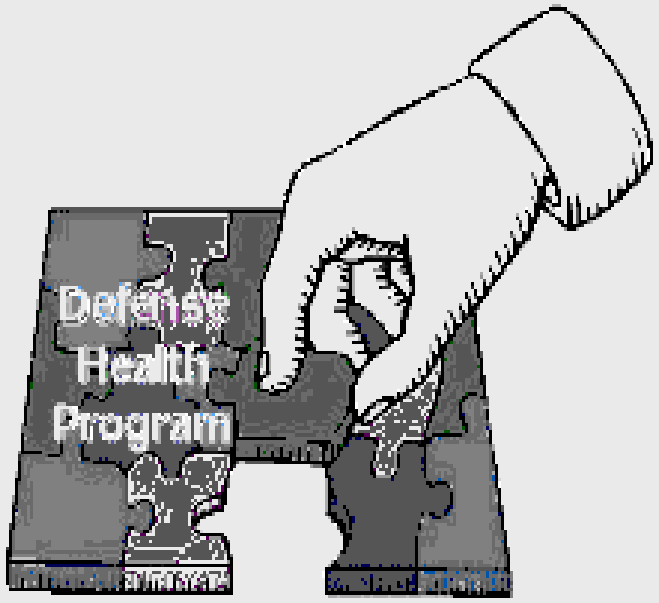


890 Medical, Dental
and Veterinary Clinics

*** Includes $1.228 B Overseas Contingency Operations Request and $9.9 B anticipated receipts from the Medicare Eligible Retiree Health Care Fund**

The Defense Health Program
…is an appropriation, not an Agency





The Objective:

An integrated, efficient funding program that reflects senior

The Quadruple Aim

Readiness

Ensuring that the total military force is medically ready to deploy and that the medical force is ready to deliver health care anytime, anywhere in support of the full range of military operations, including humanitarian missions.

Population Health

Reducing the generators of ill health by encouraging healthy behaviors and decreasing the likelihood of illness through focused prevention and the development of increased resilience.

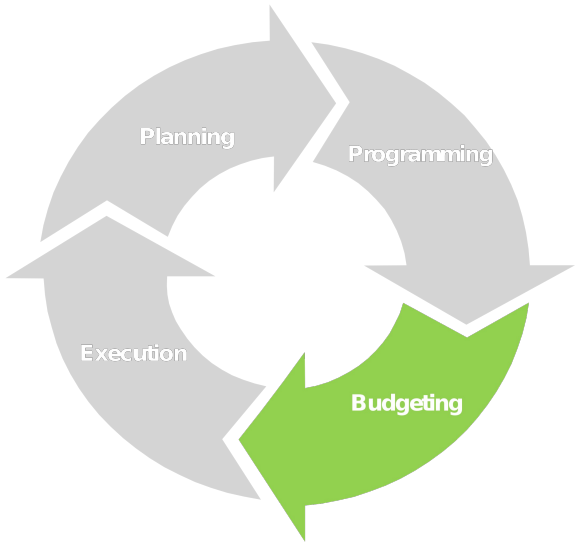
Experience of Care

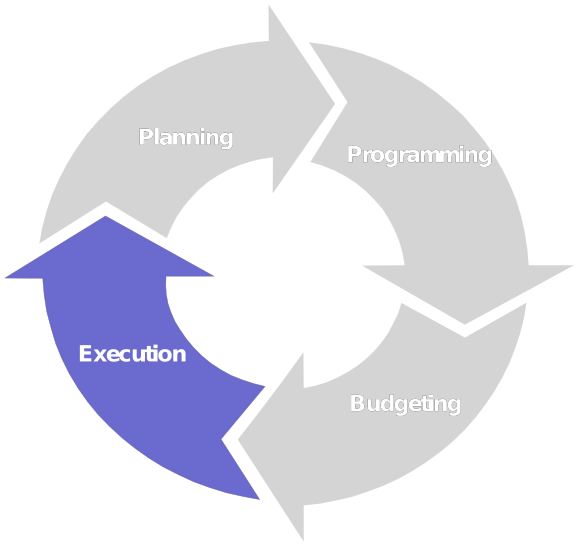
Providing a care experience that is patient and family centered, compassionate, convenient, equitable, safe and always of the highest quality.

Per Capita Cost

Creating value by focusing on quality, eliminating waste, and reducing unwarranted variation; considering the total cost of care over time, not just the cost of an individual health care activity.

Financial Processes





Plan/Program

New:
- Execution baseline plus requirements
- MHS Senior Leaders decide

Budgeting

Old: Lack of transparency

New:
- Transparent, working towards financial visibility

Execution

Old: Bills divided among Services

New:
- Review execution and source emergent requirements with any available funds

Intended Outcome of 2012-2017 Process Changes

1. Create a “shared vision” of the Defense Health Program among all Components
2. Align MHS Strategic Imperatives with planning and programming process
3. Assure that all Components have an opportunity to identify their requirements as part of the planning and programming process
4. Senior MHS Leaders to prioritize and approve programming requirements
5. Future budgets align with execution

POM Process Redesign

- Approximately 168 issues were submitted
- In order to streamline the review process, a funnel approach was developed in order to group and conduct preliminary review of issues

Super Integrating Council Process (June-July)

1.All issues were reviewed and prioritized for Senior Leader Decision

2.Additional functional Work Groups were established to review funded baseline and proposed enhancements for:

- –Patient Centered Medical Home
- –Medical Facilities
- –Centers of Excellence
- –Traumatic Brain Injury and Psychological Health
- –Wounded, Ill and Injured
- –Workforce Development

3.Results of functional Work Groups will be reviewed by Super Integrating Council (14 July) and presented to Senior Leaders for decision (21 July)

FY 2012 – 2016 POM Submission

- **Aligns funding with the MHS Quadruple Aim**

	Quadruple Aim			
	Readiness	Experience of Care	Population Health	Per Capita Cost
Patient Centered Medical Home		X	X	X
Behavioral Health	X	X	X	X
Comprehensive Pain Management	X	X	X	X
Medical Education Training Campus (Tri-Service)	X			X
Hearing Center of Excellence (HCoE)	X	X	X	
Vision Center of Excellence	X	X	X	
Physical Evaluation Board Liaison Officers	X	X		

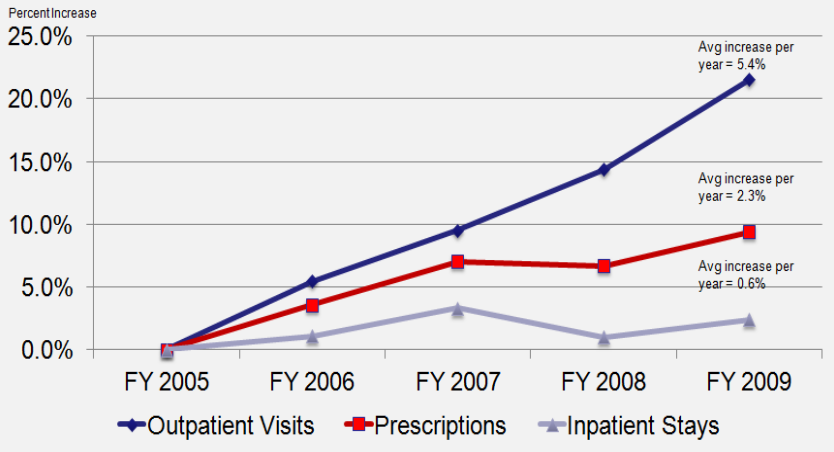
- **Must Fund requirements addressed**
  - Updated cost for facility sustainment (DoD Model)
  - Initial outfitting and transition for facilities
  - Post BRAC medical headquarters
  - Congressional mandates

Front End Assessment

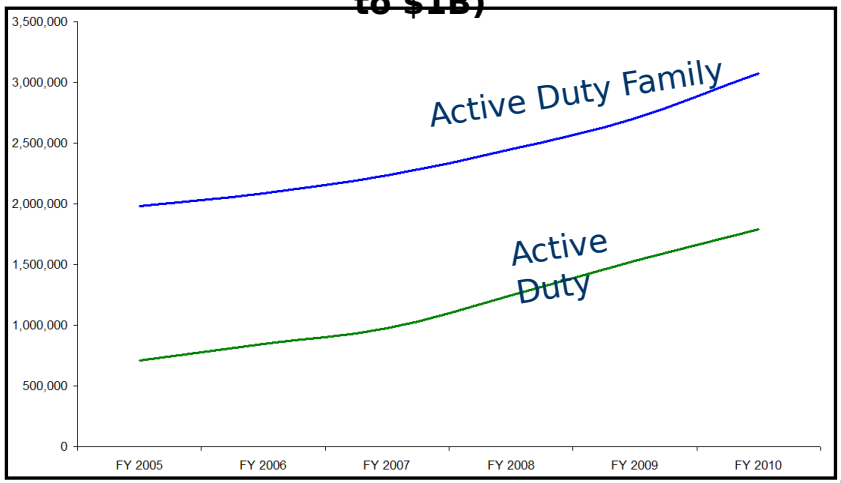
Why are the Department's healthcare costs growing?

- **Increases in new eligible beneficiaries**
  - 400,000 since 2007
- **Expanded benefits**
  - TRICARE For Life, Reserve Benefits, Traumatic Brain Injury /Psychological Health
- **Increased utilization**
  - Existing users are consuming more care (ER, Orthopedics, Behavioral Health)
- **Healthcare inflation**
  - Higher than general inflation rate
  - Consistent with civilian healthcare sector

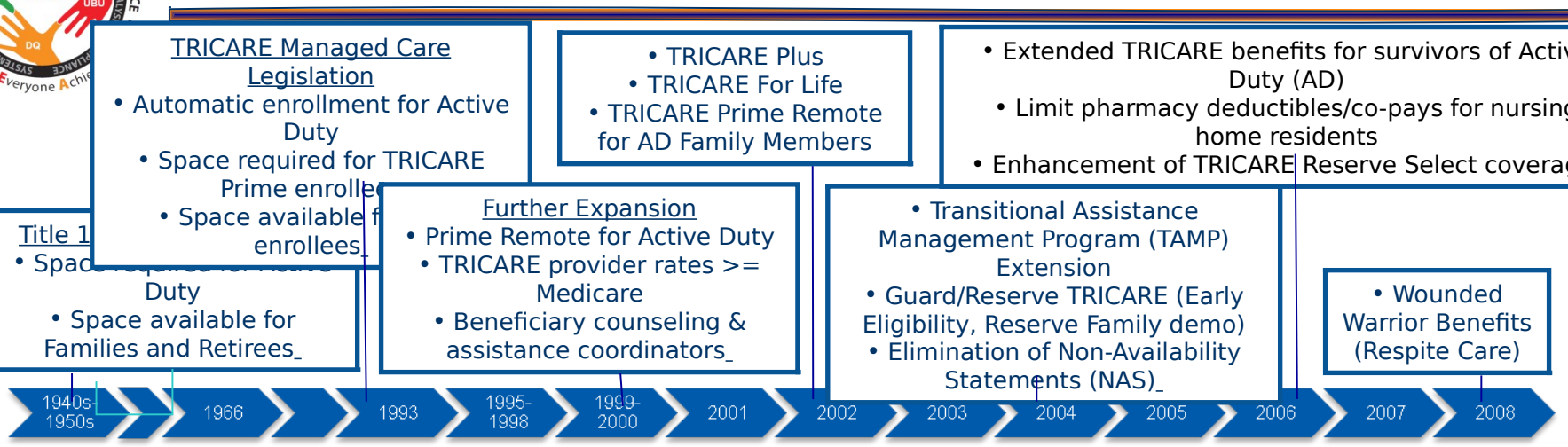
Military Health System Healthcare Utilization Trends



Behavioral Health Visits (100% increase in annual support, $500 M to $1B)



Evolution of the DoD Health Benefit



Title 1
• Space required for Active Duty
• Space available for Families and Retirees_

TRICARE Managed Care Legislation
• Automatic enrollment for Active Duty
• Space required for TRICARE Prime enrollees
• Space available for enrollees_

Further Expansion
• Prime Remote for Active Duty
• TRICARE provider rates >= Medicare
• Beneficiary counseling & assistance coordinators_

• TRICARE Plus
• TRICARE For Life
• TRICARE Prime Remote for AD Family Members

• Transitional Assistance Management Program (TAMP) Extension
• Guard/Reserve TRICARE (Early Eligibility, Reserve Family demo)
• Elimination of Non-Availability Statements (NAS)_

• Extended TRICARE benefits for survivors of Active Duty (AD)
• Limit pharmacy deductibles/co-pays for nursing home residents
• Enhancement of TRICARE Reserve Select coverage_

• Wounded Warrior Benefits (Respite Care)

CHAMPUS Legislated Benefit
• Civilian health care where MTFs do not exist
• Families and Retirees <65

TRICARE Triple Option Benefits
• Prime, Extra and Standard
• TRICARE Senior Prime demonstration

Enhanced Benefit
• Catastrophic Cap reduced to $3,000
• Enhanced TRICARE Retiree Dental Program
• TRICARE Senior Pharmacy
• Elimination of Prime co-pays for AD Family Members
• Extension of Medical and Dental benefits to Survivors School Physicals
• Entitlement for Medal of Honor recipients
• TRICARE Prime Travel Entitlement
• Chiropractic Care Program_

• TRICARE Online
• TRICARE implements HIPAA Patient Privacy Standard
• Elimination of co-pays for AD Family Members_

• TRICARE Reserve Select
• Extended Health Care Option/Home Health Care (ECHO/EHHC)
• TRICARE Maternity Care options_

• Expansion of TRICARE Reserve Select coverage to all reservists
• Three-year extension of Joint DoD/VA Incentive Program
• Planning/Management – claims processing standardization
• Expanded disease management programs
• Coverage of forensic exams for sexual assaults
• Dental anesthesia for pediatric cases

Requirements Continue to Increase

New requirements have been added to the health care budget as the result of ongoing actions

	($M)	
	FY 2010	FY 2011
Psychological Health	$ 472	$ 479
Traumatic Brain Injury	$ 178	$ 190
Wounded, Ill, and Injured	$ 661	$ 685
Total	$ 1,311	$ 1,354

Newest requirement - coverage until age 26

Premium Paid by Beneficiary as a Percent of Cost	Estimated Monthly Premium	Take Rate	Annual Cost to DoD (FY15 $)
0%	$ -	90%	$ 632
28%	$ 46.67	64%	$ 321
50%	$ 83.33	39%	$ 136
100%	$ 166.67	29%	$ -

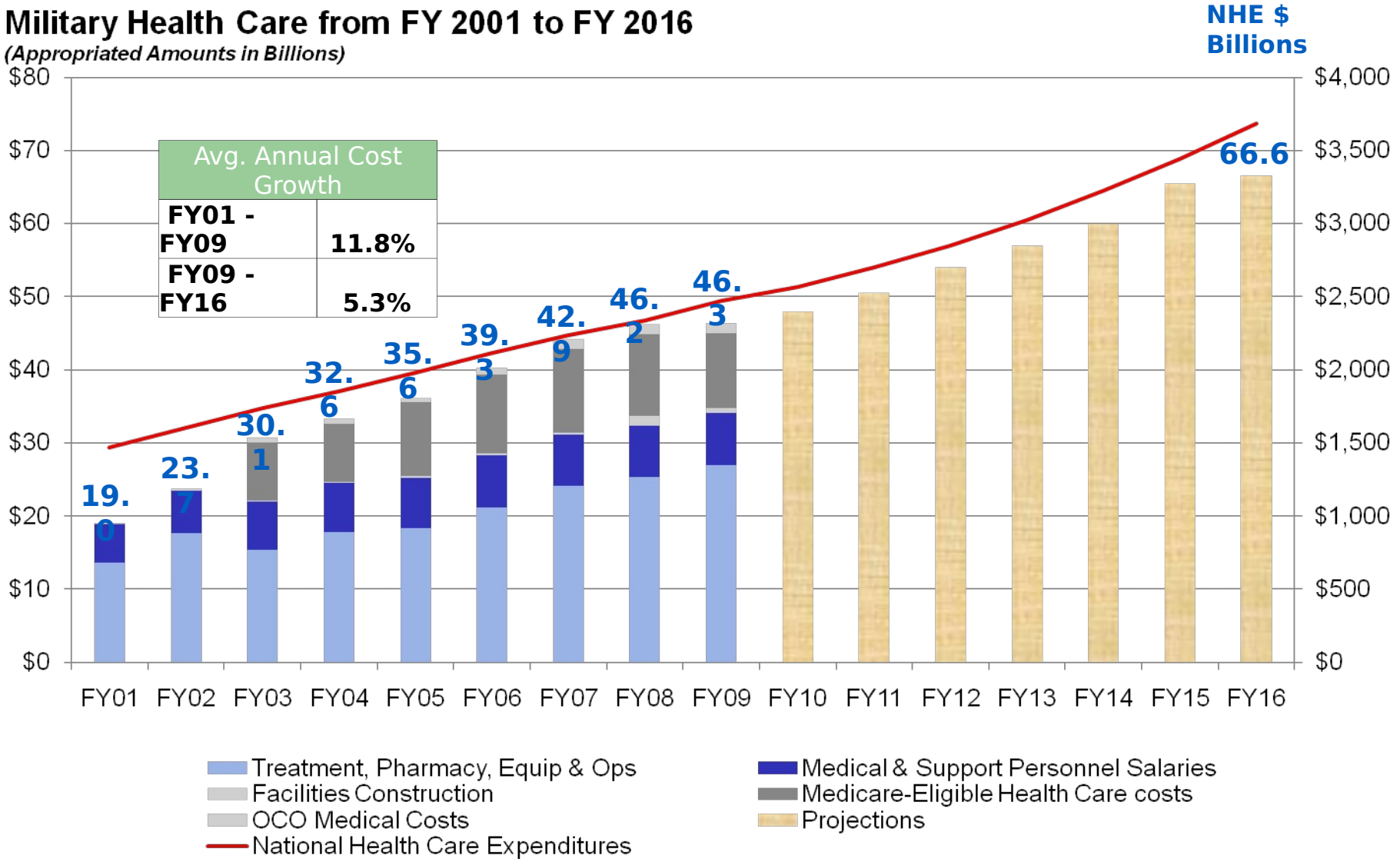
MHS Savings
Initiatives Developed Prior to FY 2011 PB

- **Unsuccessful Efforts**
  - Sustain the Benefit (STB) – $5B+ annual savings
  - Direct Care Efficiency Savings – $785M annually
  - Mil/Civ Conversion – $200M annual savings

Each Prohibited by Congress

- **Successful Efforts**
  - NDAA 2007 Legislation ($70M annual savings)
  - Marketing efforts to increase mail order utilization ($15M annual savings)
  - Federal Ceiling Pricing: DoD receives rebates from pharmaceutical manufacturers for retail prescriptions substantially reducing the cost to the Department ($500M annual savings)
  - Outpatient Prospective Payment System: Payments for outpatient care received in hospitals and ambulatory surgery centers will match Medicare rates (phased in over a four-year period) ($900M annual savings)
  - Enhance Fraud, Waste and Abuse detection and prosecution and standardize Medical Supplies and Equipment ($167M annual savings)

Despite our efforts, costs continue to rise



Health Care Proposal #1

Increase TRICARE PRIME Fees for < 65 Retirees

- **Proposal**
  - Immediate modest increase in Prime enrollment fees for all retirees under age 65 by $5/month for families OR $2.50/month for individuals (+13% for both groups)
  - Excludes: 1) Survivors (regardless if service connected death was combat related)
    2) Medically retired members and their beneficiaries
- **What This Accomplishes**
  - Introduces most modest adjustment in fees possible (fees have not changed since 1996)
  - TRICARE Prime enrollment fee for families is $460 per year (or $230 for individuals)
  - Typical similar private plans cost $2,000--$5,500/yr for families ($900—2,400/yr for individuals)
  - Indexing keeps pace with health care inflation, reduces annual battle over proposed fee changes
  - Protects most vulnerable populations from additional financial burden
  - Savings: $430M over the FYDP
- **Issues**
  - Generally opposed by Beneficiary Organizations (but some organizations may consider support) given current fiscal climate
  - Will need to explain carefully to today's TRICARE Prime retirees

Health Care Proposal #2

Pharmacy Co-Pay

- **Proposal**
  - Adjust pharmacy co-pays for all beneficiaries (except active duty) to promote use of mail order vice retail pharmacy
- **What This Accomplishes**
  - Pharmacy co-pays incentivize use of most efficient source (mail order and medical treatment facilities)
  - Savings: $2.6B over FYDP
- **Issu**
  -
  -
  -

	Generic	Brand Formulary	Tier 3 (Non-Formulary)
	Current Benefit		
Retail	$3	$9	$22
MTF	$ -	$ -	$ -
Mail Order	$3	$9	$22
	Proposed Benefit		
Retail	$5	$12	$25
MTF	$ -	$ -	$ -
Mail Order	$ -	$9	$25

Health Care Proposal #3

Background: U.S. Family Health Plan (USFHP)

- **Six former Public Health Service (PHS) hospitals provide health care to select DoD retirees (25,000); congressionally limited to 10% growth per year**
  - Johns Hopkins Medicine (MD)
  - Christus Health (TX)
  - Pacific Medical Centers (WA)
  - Martin's Point Health Care (ME, NH, VT)
  - Brighton Marine Health Center (MA, RI)
  - Saint Vincent Catholic Medical Centers (NY)

- **USFHP hospitals are unique in several ways**
  - Retirees enroll and use USFHP just like TRICARE Prime (but can remain enrolled in this Prime-like program after age 65, unlike all other retirees)
  - DoD pays full USFHP cost for over-65 retirees;
    - For all other military retirees,
      - Disenrolled from TRICARE Prime
      - Member must pay Medicare Part B premium for TFL benefit ($96.40/mo on incomes less than $85,000/yr…means tested premiums for higher incomes)
      - Medicare pays first (~80% costs); TFL Trust Fund is second payer (~20%) (funded with DoD accrual contributions)
  - USFHP hospitals' capitation rates are higher than average Medicare per capita costs

Health Care Proposal #3

U.S. Family Health Plan (USFHP)

- **Proposal**
  - Transition future USFHP enrollees to Medicare once they become eligible
  - Beginning in FY 2012, new enrollees will not remain in USFHP plan at point of Medicare eligibility
  - Members already enrolled in USFHP (whether over or under age 65) are "grandfathered" and allowed to continue participation even after becoming Medicare-eligible

- **What This Accomplishes**
  - Equity/Consistency: DoD becomes second payer to Medicare as with other Medicare-eligible retirees
  - No effect on members' hospital choices: they can continue to use USFHP hospital as regular TRICARE provider even after becoming Medicare-eligible
  - Protects current enrollees -- exceptionally reasonable transition
  - Modest added cost to Medicare ($508M for 2011-2021) -- offset by increased revenue from additional Medicare Part B enrollees
  - Lower cost to Department (other DoD Medicare-eligible retirees cost 80% less than those in USFHP)
  - Savings: $3.2B over the FYDP

- **Issues**
  - Changes to DoD mandatory vs discretionary accounts
  - Requires specific legislation

Health Care Proposal #4

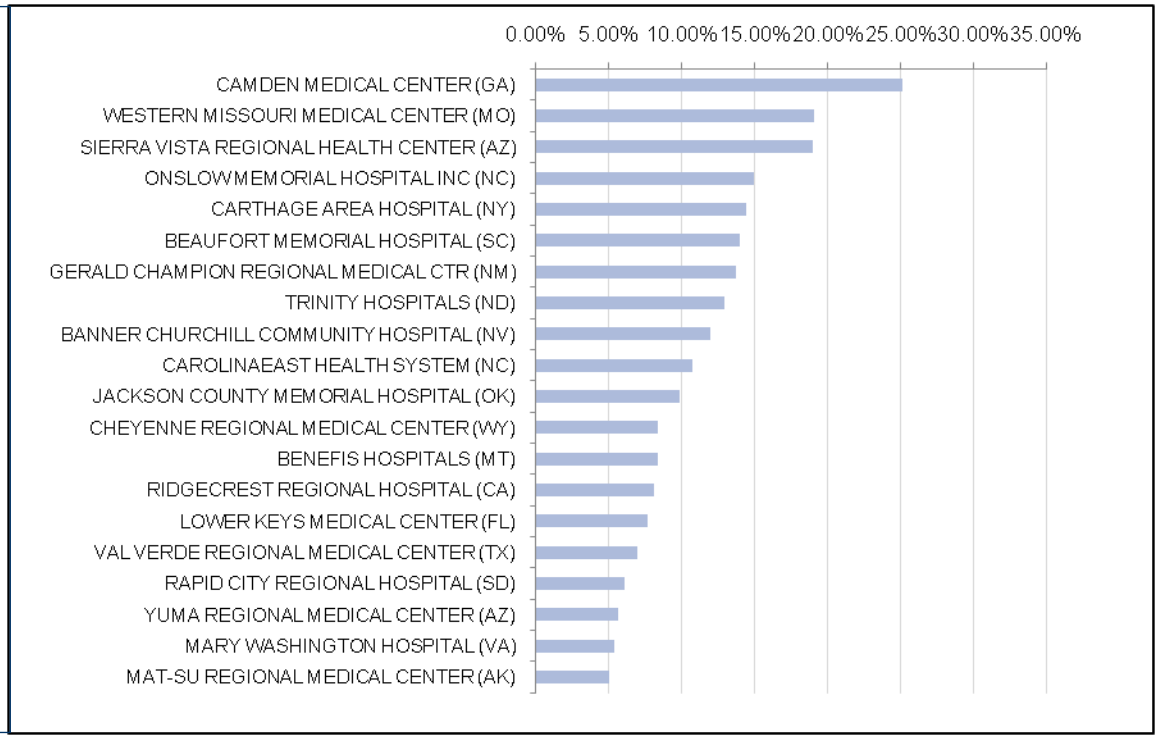
Medicare Rates at Sole Community Hospitals (SCH)

- **Background**
  - In early 2000s, CMS changed Medicare inpatient reimbursement for 420 sole community hospitals throughout the US from a charge-based system to a cost-based system
  - DoD did not immediately implement this change for bills from these hospitals for TRICARE beneficiaries
  - Only 20 of 420 hospitals have substantial TRICARE reimbursement (>5% of their volume from TRICARE)

Most Impacted SCHs

•These 20 facilities are located near MTFs; a deep dive analysis needs to be conducted to determine if phasing in Medicare payment rates to these SCHs is appropriate

•Congressman representing each SCH's area should be



Health Care Proposal #4

Medicare Rates at Sole Community Hospitals (SCH)

- **Proposal**
  - Introduce federal rule for TRICARE to adopt Medicare rates at 420 Sole Community Hospitals
  - Transition over four years to avoid major disruption to hospital business plans/revenue streams with opportunity for waivers when meeting specific criteria
- **What This Accomplishes**
  - Complies with statutory provision 10 USC 1079j(2), which mandates that TRICARE inpatient and outpatient services follow Medicare reimbursement rules to the “extent practicable”
  - Medicare rates generally 42% lower than TRICARE for these institutions
  - Savings: $400M over the FYDP
- **Issues**
  - About 5% (20) of the 420 SCHs could be significantly affected by proposed change (greater than 5% of their revenue comes from TRICARE)
  - Reduced revenue could affect hospital’s profitability
  - Waiver process will be established based on dire economic implications for the facility
  - Possible changes to mandatory accounts

Health Care Proposal #5

More Efficient Management Headquarters

- **Proposal**
  - Reduce contractor support to the TRICARE Management Activity (TMA) over two years by 760 FTEs
  - Consolidate initial outfitting and transition of hospitals and clinics
  - Optimize the supply chain
- **What This Accomplishes**
  - Creates more streamlined operations and reduction in outdated programs
  - Savings: $1.3B over the FYDP
- **Issues**
  - Complex implementation within existing contract terms
  - Careful identification of programs to be down-sized or eliminated while avoiding workload transfer to the Services

Military Health Care Issues Summary

#1	Internal Defense Health Program Efficiencies	-183	-255	-295	-266	-297	-1,296
#2:	Increase TRICARE PRIME Fees for <65 Retirees	-31	-60	-87	-114	-142	-434
#3:	TRICARE Pharmacy Co-Pay	-95	-556	-601	-634	-669	-2,555
#4:	USFHP Age Out of Medicare-Eligible Retirees	-	-740	-786	-834	-886	-3,246
#5:	Use Medicare Rates at Sole Community Hospitals	-31	-71	-92	-98	-103	-395
Potential Cumulative Savings		**-340**	**-1,682**	**-1,861**	**-1,946**	**-2,097**	**-7,926**

- **Legislation Required**

  (#4) to change USFHP entitlement for Medicare-Eligible retirees

- **OMB rulemaking required**

  (#5) to implement new rates at Critical Access Hospitals

- **Need Congressional action not to extend prohibition of increases beyond Sep. 30, 2011**

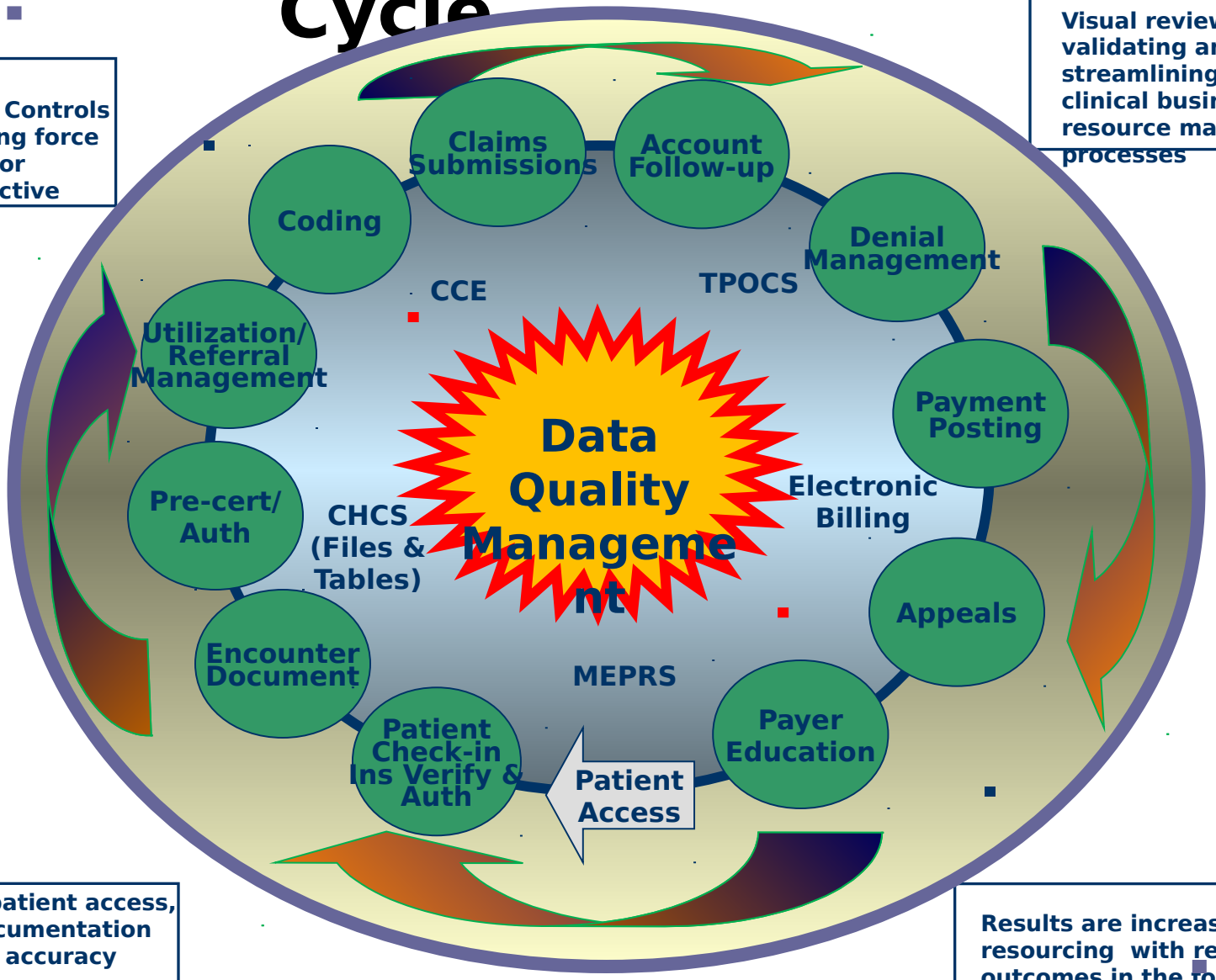
  (#1) Sec 701 – Increase in co-payments

  (#2) Sec 703 – Increase in pharmacy retail fees

MHS Revenue Cycle

Data quality Management Controls are the driving force and conduit for ensuring effective and efficient operations

Visual review for validating and streamlining major clinical business and resource management processes



Improved patient access, records documentation and coding accuracy

Results are increased resourcing with reliable outcomes in the form of usable data